Commonwealth Of Kentucky
Health Insurance Application
PY 2005

(*for Use By Agencies NOT in the State Payroll System - UPPS*)

INSURANCE COORDINATOR SECTION

Insurance Effective Date ☐☐/☐☐/☐☐☐☐ **Company Number** ☐☐☐☐☐

Home County ☐☐☐ **Work County** ☐☐☐ **Contiguous County** ☐☐☐

☐ **< Dual Employee Code**

☐☐/☐☐/☐☐☐☐ **< Deduction Start Date** ***(BOEs ONLY)***

Reason for Application

☐< New Employee ☐< New Group ☐< COBRA ☐< FSA Only ☐< Other**

☐< Open Enrollment ☐< Move Out of Service Area* ☐< Previously Waived**

* If Moving Out of the Service Area, enter the Qualifying Event Date: _____

** If you Previously Waived or marked "Other", enter the Qualifying Event Date AND a description of the Qualifying Event: _____ Date _____ Description

SECTION I: DEMOGRAPHIC INFORMATION

PLEASE PRINT

SSN ☐☐☐-☐☐-☐☐☐☐ Date of Birth ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

Smoking Status

Were you a smoker on 7/1/04? Yes ☐ No ☐

Name (First, MI, Last)

Gender

☐< Male
☐< Female

Marital Status

☐< Married
☐< Single

Street Address

PO Box / Apt. #

City, State, Zip Code

County of Residence

Country/Mail Code -- If NOT U.S.A.

/ /
Hire Date

Employer Name

( ) -
Policyholder's Primary Phone Number

SECTION II: PLAN SELECTION

1. County of Coverage (Check only one)	2. Plan Code	3. Option (Check only one)	4. Level of Coverage	5. Cross-Reference
☐< Home ☐< Work ☐< Contiguous	☐☐☐	☐< Commonwealth Essential ☐< Commonwealth Enhanced ☐< Commonwealth Premier	☐< Single ☐< Parent Plus ☐< Couple ☐< Family	☐< Yes
Name of County of Coverage	*If waiving, enter 999 and go to Section VI. If selecting coverage, see page 13 of the Health Insurance Supplement.*			*If Yes, you must complete Sections III and IV*

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

If you elected Single in Section II, box 4, go to Section VII on Page 2.

Social Security Number	Name (First, MI, Last)	Gender (Circle One)	Date of Birth (MM/DD/YYYY)	Relationship Code
		M F		
		M F		
		M F		
		M F		
		M F		

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete ONLY if you checked Yes in Section II, box 5 above.

Company Number: *(REQUIRED)*	Dual Employee Indicator, if applicable:	Was spouse a smoker on 7/1/04? *(REQUIRED)*	Is spouse a Hazardous Duty Retiree?	Spouse's Hire Date or Retirement Date:	Spouse's Deduction Start Date (If BOE employee):
☐☐☐☐☐	☐	☐ Yes ☐ No	☐ Yes ☐ No	__/__/__	__/__/__

SECTION V: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if you or your spouse has a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation.

Dependent's Social Security Number

☐☐☐-☐☐-☐☐☐☐

☐☐☐-☐☐-☐☐☐☐

Custodial Parent Name

All Dependents? ☐< Yes

Custodial Parent Address

Country / Mail Code (If not USA)

PY 2005

Policyholder's SSN

SECTION VI: SPOUSE'S FLEXIBLE SPENDING ACCOUNT

THIS SECTION MUST BE COMPLETED BY YOUR SPOUSE IF:

a) He/she is an employee of an agency that participates in the state Health Care Spending and Dependent Care Account Programs (Commonwealth Choice);
b) You and your spouse are electing a cross-reference payment option (as indicated in Section II, box 5 on Page 1 of this application); and
c) He/she wishes to enroll in the Flexible Spending Account plan.

IF YOU, THE POLICYHOLDER ON THIS APPLICATION, ARE ELIGIBLE AND WOULD LIKE TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT OFFERED BY YOUR EMPLOYER, YOU MUST COMPLETE THE ENROLLMENT FORM REQUIRED BY YOUR FSA ADMINISTRATOR.

Contact your Insurance Coordinator for specific details regarding the FSA enrollment process established by your FSA Administrator.

Spouse Health Care Spending Account

Minimum allowable combined contribution per employee is $5 per paycheck

Maximum allowable combined contribution per employee is $120 per paycheck

Spouse Contribution per paycheck: _____.____

Number of expected paychecks: X _____

Total Contribution for Plan Year: $ _____.____

EZ Reimburse Card

☐ ***< YES. I am an eligible spouse paying by cross-reference and I wish to enroll in the EZ Reimburse Debit Card plan.***

I understand that if I enroll in this plan, there is a $6 annual fee and a $0.50 charge per transaction.

Spouse Dependent Care Account

TAX FILING STATUS: **(Check One)**

☐ < **Married, filing separately** (max - $104.00 per paycheck)
☐ < **Married, filing jointly** (max - $208.00 per paycheck)
☐ < **Single, head of household** (max - $208.00 per paycheck)

Minimum - $5.00 per paycheck.
Maximum - based on tax filing status selected.

Spouse Contribution per paycheck: _____.____

Number of expected paychecks: X _____

Total Contribution for Plan Year: $ _____.____

SECTION VII: AUTHORIZATION AND CERTIFICATION

* I understand that my signature on this application creates a legal and binding contract between the Department for Employee Insurance, the Carrier and me.
* I understand that if my spouse and I pay by cross-reference, our plan can not change if one of us terminates employment.
* I understand that all benefits for my eligible dependents and me will be provided in accordance with the plan contract.
* I agree to abide by the terms and the conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the selections indicated on this enrollment form may not be changed or canceled during the year of coverage with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* I elect to participate in the Premium Conversion Program unless I sign the cancellation form. [For more information on Premium Conversion, see the Health Insurance Handbook.]
* Regarding my Flexible Spending Account, I understand that any dependents I claim reimbursement for are Section 152 dependents as defined by the Internal Revenue Code.
* Regarding my Flexible Spending Account, I further understand that any unused amount remaining in my Spending Account at the conclusion of the plan year cannot be carried forward to the next year due to I.R.S. regulations.
* I understand that I have a 90 day grace period (until March 31 of the following year) for reimbursement of eligible FSA expenses incurred during my period of coverage.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or to terminate my coverage.
* I have read both the Health Insurance and Flexible Spending Account Handbooks. My signature below certifies that the statements on this form are true and complete to the best of my knowledge.

Employee Signature _____ Date _____

Spouse Signature - ***REQUIRED if electing to pay by cross-reference*** _____ Date _____

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the state-sponsored health insurance plan. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

Employee's Insurance Coordinator Signature _____ Date _____

Spouse's Insurance Coordinator Signature - ***REQUIRED if electing to pay by cross-reference*** _____ Date _____

Health Insurance Application Instructions -- PAGE 1
FOR EMPLOYERS NOT IN THE STATE PAYROLL SYSTEM - UPPS

Reason for Application:

- **New Employee:** Check this box if you are a new employee of a company that participates in the Public Employee Health Insurance Program.
- **New Group:** Check this box if your employer is joining the Public Employee Health Insurance Program for the first time.
- **COBRA:** Check this box if you are applying for COBRA coverage (Your Insurance Coordinator will mail this application and your initial payment directly to the Health Insurance Carrier).
- **Other:** Check this box if none of the listed options apply. The Insurance Coordinator must provide a date and an explanation if "Other" is selected.
- **Open Enrollment:** Check this box if you are filling out this application for Open Enrollment.
- **Move Out of Service Area:** Check this box if you are requesting a change to your current health coverage because you have moved out of your service area. You must provide the date of the qualifying event in the space provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator.
- **Previously Waived:** Check this box if you previously waived your health insurance coverage and have now experienced a qualifying event that allows you to select health insurance coverage. You must provide the date and description of the qualifying event in the spaces provided below. All other qualifying events do not require an application and do require an ADD or DROP Form Only. You may request an ADD or DROP Form from your Insurance Coordinator and must provide supporting documentation, as required.

NOTE TO THE INSURANCE COORDINATOR: Complete the information requested within the box in the top right hand corner of the application.

- Enter the effective date of coverage.
- Enter the employee's company number.
- If the employee selects coverage in his/her Home OR Work county, you are required to enter both the Home AND Work county codes. If the employee selects coverage in his/her Contiguous county, you are required to enter the Home, Work AND Contiguous county codes. The employee is only required to name the county of residence in Section I and the county of choice in Section II, #1; however, **you are required** to provide the Home and Work County codes, and the Contiguous county code, where applicable.
- Enter the dual employee indicator, if applicable. Leave this code blank if the employee is not a dual employee.
- **Boards of Education ONLY**: Enter the employee's deduction start date.

SECTION I: DEMOGRAPHIC INFORMATION – Please PRINT clearly.

- Enter the policyholder's Social Security Number, Date of Birth, Name (First, MI, Last), Address (including County of Residence), Smoking Status, Gender, Marital Status, Employer's Name and the policyholder's Primary Phone Number. **Note: If the smoking status flag is not checked, this application will be Pended until the information is provided.**

- **Hire Date:** If you are an employee of a Board of Education, enter your contract date in the space provided. If you are an employee of any other employer, enter your hire date.

SECTION II: PLAN SELECTION

1. **County of Coverage: Check ONLY one.**
   - **HOME:** If you are electing coverage in the county where you live.
   - **WORK:** If you are electing coverage in the county where you work.
   - **CONTIGUOUS:** This is an additional choice if you live and work in certain counties in the Commonwealth designated as "Contiguous Counties". If you live and work in any of the specified counties, you could choose coverage in the county designated as a "Hospital County" that is contiguous to your county of residence. Refer to the Health Insurance Handbook for more information about this option.
   - Enter the name of your county of coverage in the space provided.

2. **Plan Code:** Enter the three (3) digit code that identifies the health insurance plan. See the Health Insurance Handbook for details.

   IMPORTANT: **If you are waiving coverage, enter 999 as the plan code and go to Section VI on Page 2.**

   WAIVING your health insurance DOES NOT automatically direct your money into a Flexible Spending Account (FSA). If you would like to enroll in an FSA, you must contact your Insurance Coordinator.

3. **Option:** Mark the box that indicates the option you are selecting. For a description of each option, see the Health Insurance Handbook. **Select only one**.

4. **Level of Coverage:** Mark the box that indicates the level of coverage you are selecting. For a description of each level of coverage, see the Health Insurance Handbook. **Select only one**.

5. **Cross-reference:** If you wish to pay by cross-reference, mark this box and complete Sections III and IV. **ONLY ONE** application is required to cross-reference. The person listed in *Section I: Demographic Information* will be the policyholder.

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION

Complete this section only if you are covering your eligible **spouse, dependent child(ren)** or have chosen the **cross-reference payment option** on your health insurance plan. Enter the required information for each dependent that you wish to cover. If you need additional space, use Page 1 of another health insurance application. Do not complete this Section if you are choosing Single coverage.

Relationship Code: Enter the appropriate relationship code as follows:

SP Spouse (your eligible spouse)
CH Child (your eligible child, step child, adopted child, foster child or your grandchild that is considered your dependent for Federal Tax purposes and who is not disabled)
DD Disabled, Dependent Child (your eligible disabled child). If your disabled dependent child is 24 years old or older, your health insurance carrier will request evidence of his/her disability annually.
CO Court Ordered Dependent Child (an eligible dependent child that you are court ordered to carry on your health insurance or an eligible dependent child of whom you have full guardianship)

SECTION IV: SPOUSE'S CROSS-REFERENCE INFORMATION

Complete this section ONLY if you and your spouse are electing to pay by cross-reference.

- Enter your spouse's company number. **Required.**
- Enter your spouse's dual employee indicator, if applicable.
- Enter your spouse's smoking status. **Required.**
- Indicate whether or not your spouse is a hazardous duty retiree.
- Enter your spouse's hire date or retirement date, if applicable. This field is needed if the policyholder elects to start a cross-reference payment method when his/her spouse becomes employed or newly retired with an agency that participates in the Public Employee Health Insurance Program.
- Enter the spouse's deduction start date. This field is only needed if the policyholder elects to start a cross-reference payment method with an employee of a Board of Education.

SECTION V: CUSTODIAL PARENT INFORMATION

Complete this section if you have a **Court Order (CO)** or an **Administrative Order** to cover an eligible dependent(s) on your health insurance who does not live with you.

- Print your dependent's social security number in the boxes provided.
- Print the custodial parent's name and address in the lines provided. If the custodial parent is the same for each dependent, check the Yes box for "All Dependents?" and complete the custodial parent's name and address only once. If the custodial parent is different for each dependent, complete the appropriate information using an additional page. **Court Ordered dependents MUST also be listed in Section III**.

Health Insurance Application Instructions -- PAGE 2
FOR EMPLOYERS NOT IN THE STATE PAYROLL SYSTEM - UPPS

Enter the social security number of the policyholder in the spaces provided on the top right hand corner of Page 2 (same as SSN in *Section I: Demographic Information*).

SECTION VI: SPOUSE'S FLEXIBLE SPENDING ACCOUNT

Complete this section with YOUR SPOUSE'S Flexible Spending Account information, only if your spouse meets all of the following:

- His/her employer participates in the state's Health Care and Dependent Care Account programs (Commonwealth Choice);
- He/she is electing to pay by cross-reference; and
- He/she is electing to enroll in the available Flexible Spending Account program. Enrollment in a Flexible Spending Account is OPTIONAL.

NOTE TO THE POLICYHOLDER REGARDING HIS/HER FSA:

Your employer does not participate in the state's Commonwealth Choice program. Therefore, if you are eligible and would like to enroll in the Flexible Spending Account program offered by your employer, you must contact your Insurance Coordinator and follow your employer's FSA enrollment guidelines.

Deadlines for completing your health insurance application and for completing your FSA application may differ.

Once you have determined that **your spouse** meets the above guidelines, continue completing this section.

Spouse Health Care Spending Account

Spouse Contribution per Paycheck: Enter the amount that your spouse wants deducted from each of his/her paychecks.
Number of Expected Paychecks: Enter the number of your spouse's expected paychecks.
Total Contribution for Plan Year: Enter the total contribution amount for the entire coverage period. (Spouse Contribution per Paycheck times Number of Expected Paychecks)

EZ Reimburse Card: To **ENROLL** in the EZ Reimburse Debit Card plan, your spouse **MUST MARK** the EZ Reimburse Card box. If your spouse enrolls, $6.00 will be deducted from his/her account. The EZ Reimburse Debit Card plan is only applicable to the Health Care Spending Account.

Spouse Dependent Care Account

Mark the tax filing status that applies to your spouse.
Spouse Contribution per Paycheck: Enter the amount that your spouse wants deducted from each of his/her paychecks.
Number of expected paychecks: Enter the number of your spouse's expected paychecks.
Total Contribution for Plan Year: Enter the total contribution amount for the entire coverage period. (Spouse Contribution per Paycheck times Number of Expected Paychecks)

Health Insurance Application Instructions -- PAGE 2 *Continued…*
FOR EMPLOYERS NOT IN THE STATE PAYROLL SYSTEM – UPPS

SECTION VII: AUTHORIZATION AND CERTIFICATION

Read the statements in this section carefully. After you have read and understood the statements, sign your name on the "Employee Signature" line and enter today's date in the line provided.

If you are applying to pay by **cross-reference**, your **spouse MUST also sign** the application on the "Spouse Signature" line. He/she **must also enter today's date** in the line provided.

Your cross-referenced spouse must have his/her insurance coordinator sign this form before you return it to your insurance coordinator.

Your **cross-reference application** will not be processed without the **four required signatures and dates**: policyholder, spouse, policyholder's insurance coordinator and spouse's insurance coordinator.

GENERAL REMINDERS:

DO NOT HOLD YOUR APPLICATION UNTIL THE END OF OPEN ENROLLMENT. RETURN YOUR APPLICATION TO YOUR INSURANCE COORDINATOR AS SOON AS POSSIBLE.

IF YOU ARE PLANNING TO PAY BY CROSS-REFERENCE, IT IS VERY IMPORTANT THAT YOU START THE APPLICATION PROCESS AS EARLY AS POSSIBLE. AGAIN, A CROSS-REFERENCE PAYMENT OPTION REQUIRES ONLY ONE APPLICATION WITH FOUR DIFFERENT SIGNATURES.

ADDITIONAL COPIES OF THE COMPLETED APPLICATION MAY NEED TO BE MADE IF PAYING BY CROSS-REFERENCE TO ENSURE THAT ALL PARTIES KEEP A COPY FOR THEIR RECORDS.